

Fertility Agents (Injectable Gonadotropins Only)

Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) OR the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER	IF the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	IF the prescription is to be filled at a retail pharmacy under the TRICARE Retail Pharmacy Program, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The provider should complete the form, sign, and date The provider may fax the completed form and the prescription to 1-877-895-1900 or 1-602-586-3911 (commercial) OR The patient may attach the completed request form to the prescription and mail it to the TMOP at: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 		<p>To request prior authorization, the provider may call this number:</p> <ul style="list-style-type: none"> 1-866-684-4488 OR The provider may complete the form, sign, date, and fax to 1-866-684-4477

Prior authorization criteria and a copy of this form are available at: http://www.tricare.osd.mil/pharmacy/prior_auth.cfm

Drug for which Prior Authorization is requested: **Follitropin alfa (Gonal-F®); Follitropin beta (Follistim®, Follistim AQ®); Urofollitropin (Fertinex®, Bravelle®); or Menotropins (Humegon®, Menopur®, Pergonal®, Repronex®)**

Step 1 Please complete patient and physician information (Please Print)

1 Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
	Secure Fax #: _____

Step 2 Please complete patient specific information:

2	Is the patient male?	<input type="checkbox"/> Yes Prior authorization criteria do not apply. Male patients who are being treated with injectable gonadotropins are not required to submit a prior authorization form to the TMOP.	<input type="checkbox"/> No Please proceed to Step 3
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Step 3 Please complete the clinical assessment:

3	Is the fertility agent being prescribed for use in conjunction with a noncoital reproductive technology, including but not limited to artificial insemination, in vitro fertilization, or gamete intrafallopian transfer?	<input type="checkbox"/> Yes Coverage is not approved. The TRICARE family planning benefit outlined in the Code of Federal Regulations does not include services and supplies related to noncoital reproductive technologies.	<input type="checkbox"/> No Coverage is approved for 1 year. Coverage is limited to 3600 IU per 30 days with no refills.
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Step 4 I certify the above is correct and accurate to the best of my knowledge.
Please sign and date:

 Prescriber Signature Date

Latest revision: June 2004